Form TNSTC: Rev 2/11/11

Tennessee TDMHSAS/DIDD PASRR Level II Change in Status Request

Complete forNF residents experiencing a significant status change (including residents hospitalized in a psychiatric unit). Fax completed form to TDMHSAS at 615.741.6086 for persons with mental illness and to DIDD at 615.253.6713 for persons with suspected MR or DD/RC

First Name:_____ Middle Initial:_____ Last Name:_____

Social Security #:___-___-___ Date of Birth:___/___/___ Marital Status: ☐M ☐S ☐W ☐D Gender: ☐M ☐F

Current Location: _____ Admission Date:_____

Street_____ City_____ State_____ Zip:_____

Type of facility: ☐ Medical Facility ☐ Psychiatric Facility ☐ Nursing Facility ☐ Community ☐ Other:_____

Receiving (or current) NF: ☐ Same as above ☐ Other_____ Date Admitting:___/___/___

Address:_____ City:_____ State:_____ Zip:_____

General:

Has the resident indicated a preference to be discharged from the Nursing Facility? ☐ No ☐ Yes

Has the resident had a recent psychiatric/behavioral evaluation? ☐ No ☐ Yes (date:_____)

Does the resident have an open-ended PAE? ☐ No ☐ Yes (date:_____)

Has the resident previously received MR/DD waiver services? ☐ No ☐ Yes (date:_____)

Does the resident have a primary diagnosis of dementia or Alzheimer's disease? ☐ No ☐ Yes

If yes, is corroborative testing available to verify the presence of the dementia? ☐ No ☐ Yes (Select all that apply):

If yes, select all that apply: ☐Comprehensive Mental Status Exam ☐Dementia work up ☐Other:_____

Has the resident been transferred, admitted, or readmitted to a NF following an inpatient psychiatric stay? ☐ No ☐ Yes

Facility: _____ Admission date:_____ Discharge date:_____

Reason for inpatient treatment: _____

Instructions: Complete all Sections below

Section A: Has the resident been previously evaluated through PASRR? ☐ No (if no, proceed to Section B)

☐ Yes (provide date:_____identify any of the following which best characterize the change, and proceed to Section C)

☐ 1. Transferred, admitted, or readmitted to a NF following an inpatient psychiatric stay as described above.

☐ 2. Increase in behavioral, psychiatric, or mood-related symptoms.

☐ 3. Behavioral, psychiatric, or mood related symptoms that have not responded adequately to ongoing treatment (e.g., significant changes in sleep, appetite, mood, energy, hopefulness, and self-care related to intellectual or developmental disability or that may have a psychiatric or psychological component).
Describe: _____

_____

☐ 4. Sudden increase or decrease in weight.
Prior weight/date: _____ Current weight/date:_____

Reason for change:_____

☐ 5. Significant physical change that in conjunction with behavioral, psychiatric, mood-related symptoms, or cognitive abilities, may influence adjustment.
Describe: _____

_____

☐ 6. Improvement or decline in medical condition, such that the plan of care or placement recommendations may require modifications.
Describe the medical improvement: _____

_____

☐ 7. Condition or treatment needs are significantly different than described in the last PASRR Level II evaluation.

If new diagnoses, specify_____ Date of diagnoses: _____
Describe how diagnosis/treatment has impacted the resident:

_____

Section B: Is the resident presenting with a newly identified suspicion of mental illness, mental retardation, or a developmental condition? ☐ No ☐ Yes (proceed to Section C)

Resident Name:_____

Section C-Mental Illness: Complete all of the following

Is the resident known or suspected as having a diagnosis of mental illness (and dementia is not the primary diagnosis)? ☐ No (proceed to Section D) ☐ Yes (if yes, identify all of the following which best characterize the resident)

1. Does the resident have any of the following Major Mental Illnesses (MMI)? ☐ No

☐ Suspected: One or more of the following diagnoses is suspected (select all that apply)

☐ Yes: (select all that apply)

- ☐ Schizophrenia
- ☐ Schizoaffective Disorder
- ☐ Psychotic/Delusional Disorder
- ☐ Major Depression
- ☐ Paranoid Disorder
- ☐ Bipolar Disorder

2. Does the resident have any of the following mental disorders?

☐ No

☐ Suspected: One or more of the following diagnoses is suspected (select all that apply)

☐ Yes: (select all that apply)

- ☐ Personality Disorder
- ☐ Anxiety Disorder
- ☐ Other diagnosis (specify): _____
- ☐ Panic Disorder
- ☐ Depression (mild or situational)

3. Currently or within the past 6 months, has the resident exhibited interpersonal symptoms or behaviors [not due to a medical condition]? ☐ No

- ☐ Serious difficulty interacting with others
- ☐ Altercations, evictions, or unstable employment
- ☐ Frequently isolated or avoided others or exhibited signs suggesting severe anxiety or fear of strangers

4. Currently or within the past 6 months, has the resident exhibited any of the following symptoms or behaviors [not due to a medical condition]? ☐ No

- ☐ Serious difficulty completing tasks that s/he should be capable of completing
- ☐ Required assistance with tasks for which s/he should be capable
- ☐ Substantial errors with tasks in which s/he completes

5. Currently or within the past 6 months, has the resident exhibited any symptoms related to adapting to change? ☐ No ☐ Yes: (select all that apply)

- ☐ Self injurious or self mutilation
- ☐ Suicidal talk
- ☐ History of suicide attempt or gestures
- ☐ Physical violence
- ☐ Physical threats(potential for harm)
- ☐ Severe appetite disturbance
- ☐ Hallucinations or delusions
- ☐ Serious loss of interest in things
- ☐ Excessive tearfulness
- ☐ Excessive irritability
- ☐ Physical threats(no potential for harm)
- ☐ Other major mental health symptoms (this may include recent symptoms that have emerged or worsened as a result of recent life changes as well as ongoing symptoms. Describe Symptoms: _____

Section D-Mental Retardation/Developmental Disability: Complete all of the following

Is the resident known or suspected as having mental retardation or developmental disability (federally referred to as a condition related to mental retardation)? ☐ No (proceed to E) ☐ Yes (identify all of the following which best characterize the resident)

1. ☐ Evidence of a cognitive or developmental impairment that occurred prior to age 18

2. ☐ A diagnosis which affects intellectual or adaptive functioning (select all that apply)

☐ Autism ☐ Epilepsy ☐ Blindness ☐ Cerebral Palsy ☐ Closed Head Injury ☐ Deaf

☐ Other:_____

***If one of the above was identified,* did this condition develop prior to age 22?** ☐ No ☐ Yes

3. ☐ Substantial functional limitations in any of the following? ☐ No ☐ Yes (select all that apply)

☐ Mobility ☐ Self-Care ☐ Learning ☐ Self-Direction ☐ Understanding/Use of Language

☐ Capacity for living independently

Section E: Check all applicable information and attach records to this submission

Include any consultations or evaluations that support and/or substantiate the mental health, physical and/or behavioral change(s) noted on this form. Select attachments included:

☐ **Physician's Notes** ☐ **Nursing Notes/Summary** ☐ **MAR Sheet(s)** ☐ **Hospital Records**

☐ **Medical Consultation(s)** ☐ **Psychiatric Evaluation(s)** ☐ **Intellectual Assessment(s)**

☐ **Other (List):** _____

Section F: REFERRAL SOURCE SIGNATURE-To be completed by RN or Social Worker		
Print Name:	Signature:	Date: / /
Agency/Facility:	Phone:	Fax:

Section G: PASRR OUTCOME-To be completed by TDMH and/or DIDD Authority		
Print Name:	Signature:	Date: / /
Outcome: ❑ Not a PASRR significant status change ❑ Document review of clinical information ❑ Level II onsite evaluation	Comments:	Phone: